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ABSTRACT

This paper analyzes and synthesizes information on assessment of attention deficit disorder (ADD), to provide guidance to states as they formulate policies and practices. The paper presents an overview of ADD from an educational perspective, focusing on student characteristics, developmental patterns, and coexisting disorders. Schoolwide assessment of all students is recommended, to screen for problems and to monitor individual social and academic progress. This schoolwide assessment would be followed by modification of learning environments, and subsequent individual evaluation of only those students in need of additional assistance. The paper identifies the best composition for a multidisciplinary assessment team, describes phases in the assessment process, and describes various strategies appropriate for individual student assessments in school settings. Instruments used in the assessment process are provided, including the Conflict Behavior Questionnaire, Skamp Rating Scale, Home Situations Questionnaire-Revised, School Situations Questionnaire-Revised, and Academic Performance Rating Scale. A brief paper by Jeanne M. Kincaid titled "Legal Considerations Pertaining to the Evaluation of ADD/ADHD" and a paper by Perry A. Zirkel titled "A Checklist for Determining Legal Eligibility of ADD/ADHD Students" are appended. A list of parent support groups and information centers concludes the paper. (Contains 26 references.) (JDD)

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School Based Assessment of Attention Deficit Disorders

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Introduction

During the past decade Attention Deficit Disorder has become a widely used label in our public school system for categorizing students. Because ADD does not carry the stigma attached to many other labels, such as emotionally disturbed or behavior disordered, it has become a catchall classification that attempts to explain a variety of behaviors.

As a result of a February 18, 1992 OSEP ruling, schools are not required to include medical evaluations as a part of ADD assessment "if the school district believes that other effective means of measuring ADD are available" (Judy A. Schrag, personal communication, Feb. 18, 1992). Educators are finding it difficult to fit a traditional medical model into an educational one. To further complicate the issue, eligibility criteria and methods of assessment of Attention Deficit Disorders vary considerably from state to state. Added to this is the fact that there is little agreement among experts on a definitive definition of this disability (Barkley, 1990).

In a study of characteristics associated with Attention Deficit Disorder titled "ADD: Acronym for any Dysfunction or Difficulty," Goodman and Poillion (1992) reviewed 39 educational sources and identified 69 characteristics cited as descriptive of students with Attention Deficit Disorders. The researchers discovered no single characteristic which all authors agreed was exhibited by students with ADD; in fact, more than 10% of the characteristics they identified appear to contradict one another. Goodman and Poillion also reviewed studies comparing the characteristics of students categorized as ADD to characteristics of other students with disabilities and discovered no significant differences.

With such variation in opinion and current thought, it is not surprising that many students may be wearing a label that does not fit their individual learning needs.

Scope Of This Paper

Because the 1992 OSEP ruling clearly places more responsibility on schools for the assessment of students who may have attention deficit disorders, questions have arisen concerning the assessment process. In an effort to provide guidance to states as they formulate new policies and practices, we have analyzed and synthesized the most current information available on this topic. In this paper we seek to:

- present an overview of current thoughts concerning Attention Deficit Disorders from an educational perspective,
- contrast traditional assessment strategies with an alternative model,
- identify the best composition for a multidisciplinary assessment team,
- describe phases of evaluation which comprise the assessment process, and
- provide a description of various strategies appropriate for individual student assessments which may be used in school settings.

Characteristics Of Students

Making Sense Of The Labels

The most common characteristics of students with Attention Deficit Disorder are inattention, impulsivity, and hyperactivity. Although these characteristics are exhibited by all children to some degree, in students with Attention Deficit Disorder, these characteristics are both prolonged and more pervasive in a wider range of situations and circumstances (Parker, 1992, p. 1). Similarly, student demonstrations of inattention, impulsivity, and hyperactivity are consistently manifest at developmentally inappropriate levels. Attention Deficit Disorder is present in varying degrees of severity and does not affect all students in the same way; thus, "there is no prototypic ADD child" (Fowler, 1991, p. 28). Each student has a unique set of strength and weaknesses he or she brings to the school environment.

Under current standards of the DSM III-R, a student must exhibit eight symptoms from a possible set of 14 to be considered a possible candidate for an ADHD (Attention-Deficit Hyperactivity Disorder) diagnosis. The onset of these symptoms must have occurred prior to the age of seven and the behavior must have been present for at least six months (see chart on page 5). The presence of these symptoms is necessary for a diagnosis but *not sufficient alone* to make such a diagnosis.

The DSM III-R also added a second diagnostic category for children who show evidence of inattention and impulsivity , but who are not hyperactive—Undifferentiated Attention Deficit Disorder (UADD). Children with UADD (approximately 30% of all children with Attention Deficits) tend to be underactive compared to their hyperactive counterparts. Teachers describe them as lethargic, drowsy, depressed, and sometimes confused. They have a higher rate of associated learning problems than their hyperactive peers and may develop emotional problems related to depression, anxiety, and low self-esteem. Children with UADD are less visible than their ADHD counterparts and thus represent a potentially underidentified, underserved group at significant risk for academic failure (Epstein et al, 1991). For the purposes of this paper we have used the term "Attention Deficit Disorder" in a broad context to include all variations of the disability.

Developmental Patterns

Problem behaviors resulting from Attention Deficit Disorder usually appear at an early age and often persist throughout life, changing characteristics with different stages of development. Although hyperactivity and aggressive behavior may diminish with age, academic difficulties, behavioral problems, and low self-esteem persist, often causing adolescents with Attention Deficit Disorders to develop serious behavioral and emotional problems. Various problems related to Attention Deficit Disorder may manifest themselves at different stages of development (Fowler, 1991; Parker, 1992; Lerner & Lerner, 1991; Campbell, 1990; Teeter, 1991).

For instance, compared to other **infants**, a child with Attention Deficit Disorder may cry excessively and/or be difficult to soothe. A **toddler** may seem more noncompliant than other toddlers. A **preschooler** may resist routines and exhibit an insatiable appetite for stimulation and high energy levels. Once in **elementary** school, the child with Attention Deficit Disorder may be disruptive, inattentive, easily distracted, restless, and fidgety. The student may have poor social skills as well as poor academic performance. He or she may be characterized as consistently inconsistent. As an **adolescent**, the student may be antisocial, "at risk" for serious conduct

disorders, and experience frequent academic failure; his or her self-esteem may be poor. This student, too, may be characterized as consistently inconsistent. As an **adult**, ADD-related problems may manifest themselves in depression, low self-esteem, and lack of social skills

Prevalence Of ADD

Conservative estimates indicate that between three and five percent of school-aged youth have some form of Attention Deficit Disorder. Boys are at least three times more likely to have an attention disorder than girls (Barkley, 1991). Boys with Attention Deficit Disorders tend to be more aggressive, impulsive, and disruptive than girls, who manifest less overt symptoms that are sometimes undetected; thus girls may be more at risk than boys for long term academic, social, and emotional difficulties. Attention Deficit Disorder is an equal opportunity disability which occurs across all socioeconomic, cultural, and racial backgrounds and affects children and adults of all intelligence levels (Fowler, 1991, p. 3).

Coexisting Disorders

Students who have Attention Deficit Disorders often have coexisting difficulties, especially those relating to learning, behavior, and emotional development. Since there is a significant overlap between ADD and other disabilities, school personnel identifying students with ADD should also be alert for signs of coexisting disabilities such as learning disorders, behavior disorders, and emotional disorders

ADD and Learning Disorders. Students with Attention Deficit Disorders have a greater likelihood than other students of having a learning disability. (Parker, 1992, p. 7) The relationship between Attention Deficit Disorder and Learning Disabilities is still being researched, and these problems appear to often overlap. Educators should be aware of this co-existence for assessment as well as educational planning.

ADD and Behavior Disorders. Students with Attention Deficit Disorders also have a greater likelihood than other students of exhibiting behavior disorders. Between 30 and 90% of children diagnosed with ADHD have behavioral problems, often manifested in aggressive and antisocial actions.(Parker, 1992, p. 8) Many students with ADD are first referred for evaluation and treatment because of behavioral problems.

ADD and Emotional Disorders. Students with Attention Deficit Disorders show a higher incidence of low self-esteem, anxiety, depression, and socialization problems than other students, stemming from the frustration, rejection, and failure frequently accompanies their disability (Parker, 1992, p.9). Recognition of these students' vulnerability to emotional problems is important for educators to remember.

Characteristics of Children with Attention Deficit Disorder

DSM-III-R Diagnostic Criteria for Attention-Deficit Hyperactivity Disorder

Note: Consider the criterion met only if the behavior is considerably more frequent than most people of the same mental age.

A. A disturbance of at least six months during which at least eight of the following are present:

1. often fidgets with hands or feet or squirms in seat (in adolescence may be limited to subjective feelings of restlessness)
2. has difficulty remaining seated when required to
3. is easily distracted by extraneous stimuli
4. has difficulty awaiting turns in games or group situations
5. often blurts out answers to questions before they have been completed
6. has difficulty following through on instructions from others (not due to oppositional behavior or failure of comprehension)
7. has difficulty sustaining attention in tasks or play activities
8. often shifts from one uncompleted activity to another
9. has difficulty playing quietly
10. often talks excessively
11. often interrupts or intrudes on others, e.g., butts into other children's games
12. often does not seem to listen to what is being said to him or her
13. often loses things necessary for tasks or activities at school or at home (e.g., toys, pencils, books)
14. often engages in physically dangerous activities without considering possible consequences (not for the purpose of thrill-seeking) e.g., runs into street without looking

Note: The above items are listed in descending order of discriminating power based on data from a national field trial of the DSM-III-R criteria for Disruptive Behavior Disorders.

B. Onset before the age of seven

C. Does not meet the criteria for a Pervasive Developmental Disorder

Criteria for Severity of Attention-Deficit Hyperactivity Disorder

Mild: Few, if any signs in excess of those required to make the diagnosis and only minimal or no impairment in school or social functioning.

Moderate: Signs or functional impairment intermediate between mild and severe.

Severe: Many signs in excess of those required to make the diagnosis and significant and pervasive impairment in functioning at home and school and with peers.

Note: From ***Diagnostic and Statistical Manual of Mental Disorders*** (3rd ed., rev.) by the American Psychiatric Association, 1987, Washington, DC: Author. Copyright 1987 by the American Psychiatric Association. Reprinted by permission.

Assessment

Traditional Assessments

Traditional assessments begin with a focus on the learning and/or behavioral problems manifested by students in a classroom setting and then search for a reason or cause to explain the problem. Evaluations conducted to identify the cause of a student's difficulties often become an individual "search for pathology" that is both expensive and potentially detrimental to the student (Sarason & Doris, 1979). Results of the evaluation often produces a label, a placement decision, and prescribed formula for educational and behavioral interventions deemed appropriate for the student's disability. Although this label may entitle students to instructional support under federal and state laws, special education programs often stigmatize students, remove them from the regular classroom, and isolate them from peers ("Inappropriate categorization," p. 2).

An Alternative Assessment Strategy

A more comprehensive and practical approach than the tradional approach would be to institute a schoolwide assessment procedure which screens for problems and monitors the individual social and academic progress of all students (Stoner and Carey, 1992). Rather than investing school resources in trying to find an appropriate disability label for a student and then moving to educational interventions, with this strategy schools do the interventions as a matter of course with *all* students. Using a schoolwide assessment approach, only those students in need of additional assistance after modifications have been made to their learning environment are further evaluated individually. Such an evaluation helps define what additional accommodations these students need in order to learn effectively.

Thus, a student who may be labeled with a disability by educators who follow traditional methods of assessment may never need to be identified as disabled using this alternative assessment strategy because the learning environment has been adapted to accommodate the student's individual learning needs.

The alternative assessment strategy employs a systems approach to understanding Attention Deficit Disorders. Instead of regarding ADD simply as a disability which resides within an individual, it is viewed as a social construct. This systems view conceptualizes the disability in terms of both the individual and his relationship to the environment. Although ADD may have neurobiological origins, it is understood as a difficulty in responding to certain expectations and external demands. Such an approach stresses not just attempting to change the behavior of the individual, but changing expectations, demands, and ways of interacting with the individual so that the student can succeed (Fowler, 1991, p. 4 - 5).

Because ADD is a developmental disability, its manifestation is viewed within the context of a student's environment. Whether a student's behavior proves problematic in a school setting varies according to the situational demands of the classroom and the student's developmental stage (Fowler, 1992, p. 11) What is conceived of as a disability may actually be an inappropriate match between the current skills of the student and the environment. For schools, this systems approach means adapting the environment to the individual needs of students rather than insisting that students fit into a system where they are likely to fail.

Prereferral Intervention Programs

At least two states, Virginia and Florida, have instituted prereferral intervention programs which help eliminate unnecessary assessments and assist regular education teachers carry out interventions with difficult-to-teach students (Parker, 1992, p. 126). A team approach is used to determine the design and application of interventions to be tried. The team frequently consists of various regular and special education teachers, school psychologists, physicians, social workers, behavior management specialists, etc. who define the problem, collect pertinent information about the student, and suggest intervention strategies. The team member designated to be the case manager has the responsibility to follow the student and monitor team decisions and intervention outcomes. The case manager assists the student's teacher, parents, and other support personnel in assessing the student's difficulties and implementing systematic instructional modification and social/behavioral support strategies until either the student shows improvement or it is decided that more intensive intervention is necessary. If interventions do not result in improvements, an individual assessment is initiated.

The advantages of a prereferral intervention program are outlined in The ADD Hyperactivity Handbook for Schools (Parker, 1991):

> Prereferral intervention offers several advantages to students, parents, and teachers. If the process is successful, the students benefit by receiving intervention early, rather than having to exhibit chronic failure before the decision is made to evaluate for special education. Students also benefit from staying with peers in regular education and in not being labeled. The intervention they receive in the regular classroom is ongoing throughout the entire day rather than just a portion of the day while they are in the resource special education class. Teachers benefit by learning new problem-solving strategies which can then be applied to other students in the future. The methods they implement can be shared with their colleagues through informal networking in the preconsultation process. Teachers feel a positive sense of camaraderie which comes from working on a professional team to develop effective methods of reaching students. School systems benefit from having better trained teachers who are capable of providing high quality instruction in regular education classes. Schools which emphasize a prereferral intervention model may be able to service more students quickly than will schools whose programs rely primarily on a special education model to assist high risk students. (129).

Increasingly, regular education teachers are assuming more responsibility to make classroom adaptations and use appropriate educational interventions with students in need of additional educational or behavioral support. Thus, Attention Deficit Disorder is an issue where responsibilities in regular education and special education overlap and communication among all school personnel involved in the education of a student is vital. In his letter to principals introducing the district's Attention Deficit Disorder Response Plan, Broward County, FL superintendent Virgil Morgan reminds educators: "It is important to note that students can have difficulty attending and not have ADD and that students can have ADD without being disabled learners. It is anticipated that most ADD students will be served with accommodations in the regular classroom." (Virgil Morgan, personal communication, July 1, 1992)

Individual Assessment

Under both the Individuals with Disabilities Education Act and Section 504 of the Rehabilitation Act of 1973, state education agencies and local school districts have an affirmative obligation to evaluate any student suspected of having an Attention Deficit Disorder. Although Attention Deficit Disorder is not a separate category of disability under IDEA, students may qualify for special education services under the "Other Health Impaired," "Seriously Emotionally Disturbed," or "Specific Learning Disability" categories. Students with less severe disabilities who do not qualify for special education services may nonetheless be considered disabled under Section 504 if their disability "substantially limits" their ability to learn ("Educating Students").

Attention Deficit Disorder is a difficult condition to diagnose. There is no specific test to verify its presence; in addition, a diagnosis may be complicated by the presence of other disabilities with similar symptoms. Medical problems, emotional disturbances, anxiety-related problems, vision and hearing problems, family stress, and other disabilities may also produce behavioral symptoms similar to ADD. Thus, a careful assessment is needed to determine if a student has an Attention Deficit Disorder. A diagnosis of Attention Deficit Disorder is most accurately made on the basis of information gathered from a variety of sources and evaluations.

Assessment Team Design

If a schoolwide screening assessment indicates a student might have an Attention Deficit Disorder, then an individual assessment is needed. Traditionally, ADD has been a medical diagnosis made by physicians, but in a 1992 Digest of Response, the Office of Special Education Programs (OSEP) determined that a school district *may* require a medical evaluation by a licensed physician if it believes such a diagnosis is necessary; if, however, "the school district believes that other effective means of measuring ADD are available, then qualified personnel other than licensed physicians may be used to conduct the evaluation." The digest stipulates that the evaluation must be conducted by a multidisciplinary team including "at least one teacher or other specialist with knowledge in the area of the suspected disability" (Judy A. Schrag, personal communication, Feb. 18, 1992). This specialist will often be a school psychologist with training in the assessment and management of Attention Deficit Disorders who serves on the multidisciplinary team with social workers, teachers, and outside physicians or psychologists who may act as consultants to the team (Fowler, 1991, p. 25). The preferred assessment approach links educators with resource professionals in the community who bring together their individual expertise in collaborate strength.

To conduct an individual assessment for ADD, educational personnel should have adequate training in general psychoeducational assessment of students, in the specific assessment of Attention Deficit Disorders, and in the use of nonstandard procedures for assessing students who may be subject to bias because of racial, ethnic, cultural, or socioeconomic factors (Fowler, 1992, p. 25). Such training can be obtained through college course work, inservice training programs, and continuing education workshops.

Ruling Out

A critical facet of the assessment process is the consideration of other conditions which manifest similar symptoms frequently confused with Attention Deficit Disorders. These include:

- Central Auditory Processing Disorder
- Psychiatric Disorders such as anxiety disorders, depression, bi-polar disorders
- Hyperthyroidism
- Seizure Disorders
- Neuropsychiatric disorders such as mental retardation, autistic disorder, and Gilles de la Tourette Syndrome

Additionally, certain medications can cause side effects similar to ADD-like symptoms. Parenting styles and family environments can also affect student behavior. Students who live in families with structure or discipline have a strong likelihood of exhibiting symptoms of inattention, impulsivity, and hyperactivity but may have no neurobiological basis for their behavior, as is true with ADD. (Parker, 1992)

The Assessment Process

It would be difficult to imagine a more ideal setting for the assessment of Attention Deficit Disorder than the school environment. While students are at school six hours daily—engaging in a variety of academic and social activities across a wide spectrum of settings—they can be observed by both teachers and peers (Atkins and Pelham, 1992). Although initial symptoms of Attention Deficit Disorder may appear in children prior to the age of six, because many preschool children frequently exhibit ADD-like symptoms, it is often a child's elementary teacher who first identifies the possibility of an Attention Deficit Disorder. The school environment places greater demands on students than they have previously experienced for duration and intensity of attention.

A behavioral assessment approach is generally used to evaluate students; emphasis is placed on collecting reliable information from interviews with parents and teachers as well as observations of the student's performance in a variety of settings and tasks. Because of the complexity of the disorder, an assessment should be cross-situational as well as multidimensional, examining how a student functions in various settings and in different areas of development. To be comprehensive, the assessment should involve a multidisciplinary team, including parents and teachers as well as at least one professional with expertise in the area of Attention Deficit Disorders.

Although a variety of assessment strategies may be used, the most important of these are interviews with parents and teachers, questionnaires completed by parents and teachers, and observations of student behavior across multiple settings and various task situations (Barkley, 1990; DuPaul, 1992). In Attention Deficit Disorder: School-Based Practices: A Final Report (Burcham & Carlson, 1993), a core team of specialists in the area of Attention Deficit Disorders determined that a school-based identification practice should do the following (Burcham & Carlson, 1993):

- have a positive impact for the child with ADD and/or the family;
- have practical value or meaning in educationally intervening with the child with ADD and/or the family;
- have potential for replication at other sites with the expectation of similar results;
- acknowledge the benefits of early detection; address the three major components of the disorder (inattention, impulsivity, and overactivity);
- focus on strengths as well as needs; show evidence of collaborative involvement with families and the community;
- and address the issues of cultural diversity.

Phase One

Once a student is identified through a screening process as suspected of meeting eligibility criteria as stipulated by the DSM III-R, the assessment process should proceed. This phase may include any number of the following components:

- parent interviews
- teacher interviews
- student interviews
- behavior rating scales (teacher)
- behavior rating scales (parent)
- peer ratings
- school records
- psychoeducational testing
- specialized testing
- medical evaluation

Parent Interviews

Parents can provide the most comprehensive view of the child's previous development and current adjustment, including particular ADD characteristics displayed within the home. Parents can help provide information on the child's developmental and medical history, family background, relationships with peers, and perceptions of their child's academic performance. The interview process also provides an opportunity to learn more about family relationships and the student's home environment. An important component of this interview is determining how well the family has coped with the student's difficulties.

The Conflict Behavior Questionnaire (CBQ; Robin & Foster, 1989), reprinted on pages 15 to 21 and the Issues Checklist (IC; Robin & Foster, 1989) can be used to assess the degree of conflict and quality of communication in parent-adolescent relationships. In both evaluations, parents and adolescents complete parallel versions of the same questionnaire.

Teacher Interviews

Interviews with teachers are recommended as an opportunity to collect information about the child as well as to assess the classroom environment and teaching strategies currently being used. The teacher can offer insight into the student's academic strengths and weaknesses along with social, emotional, or behavioral characteristics. During the interview, the teacher and interviewer can discuss the student's adjustment as it relates to the instructional environment created by the teacher.

Student Interviews

An informal interview with the student can reveal important information regarding family, school, and social interactions. The interview can also reveal information about a student's feelings which may affect his adjustment and behavior. Students as young as nine years of age can also play also a key role in assessing their own learning skills and designing their own interventions by helping to identify their individual strengths and weaknesses (Carter-Sasano, 1993).

Observations of students' behavior during interview sessions, however, should not be considered indicative of their behavior in other settings; students may exhibit excellent attention and self-control in a one-on-one setting but exhibit more typical ADD symptoms in more commonplace settings.

The Child Behavior Checklist—Youth Self-Report (CBCL-YSR; Achenback & Edelbrock, 1987) is a useful screening measure for symptoms frequently associated with ADD. Responses to 112 items included in the report yield profiles in two separate scales: competence and behavior problems.

Behavior Rating Scales for Teachers

Behavior rating scales offer a standard set of behaviors to be evaluated and compare a student's behavior with others of the same sex and age to determine if those behaviors are exhibited to a significantly greater or lesser degree in relation to peers. Rating scales are economical in terms of cost and time expenditure. Their major detraction is the fact that they are subject to rater bias and thus may provide an inaccurate picture of the student. Additionally, data from these ratings rely upon the teachers' familiarity with the student. Elementary teachers, who typically spend several hours with their students daily, may be more familiar with individual students than middle or high school teachers. Therefore, when rating secondary students, it is essential to gather data from several teachers.

Some of the more common rating scales used to measure a teacher's appraisal of a student's behavior include:

- ADD-H Comprehensive Teacher Rating Scale
- Child Behavior Checklist (appropriate for child or adolescent evaluation)
- School Situations Questionnaire-Revised
- ADHD Rating Scale (appropriate for child or adolescent evaluation)
- Conners Teacher Rating Scales
- SNAP Rating Scale
- IOWA-Conners Rating Scale
- Child Attention Profile

The Skamp (Swanson, 1992) is a recently developed 10-item rating scale which evaluates target classroom behaviors associated with Attention Deficit Disorder. Item selection for inclusion in the Skamp was based on the observation that students have attention problems which lead to decreased academic productivity and deportment problems which lead to classroom disruptions. Item ratings reflect the severity of behavioral problems in these two areas. Because each Skamp item represents a behavior associated with attention and deportment, there is a clear link between assessment and treatment of the educational manifestations of Attention Deficit Disorder. Appropriate strategies to increase academic productivity and decrease deportment problems in students can be implemented, based on the results of the rating scale. The Skamp has yet to be evaluated by statistical procedures. This rating scale has been reproduced on page 24.

A detailed description of behavior rating scales for teachers as well as information on where to order these assessment tools are available in Russell Barkley's **Attention Deficit Hyperactivity Disorder: A Handbook for Diagnosis and Treatment** (1990).

Behavior Rating Scale for Parents

Similar to behavior rating scales for teachers, these scales are completed by parents and measure their appraisal of their child's behavior outside of school. Parents can be excellent sources since they have observed their child's behavior in a variety of situations across an extended duration of time. However, their objectivity may be compromised by their desire to respond in certain ways which may not be entirely realistic and their lack of exposure to same-age students. Some of the more common parent instruments used include :

- Child Behavior Checklist (appropriate for child or adolescent evaluation)
- Home Situations Questionnaire-Revised
- ADHD Rating Scale (appropriate for child or adolescent evaluation)
- Yale Children's Inventory
- Conners Parent Rating Scales
- Personality Inventory for Children

The Home Situation Questionnaire-Revised assesses the severity of behavior problems in different settings. The scale lists 14 home situations and asks parents to rate the degree of behavior problems their child manifests in each setting. The scale produces two scores: number of problem situations and the severity of behavioral problems. These scores are then compared to norms for peers of the same age and sex to determine significance. In a similar fashion, the School Situations Questionnaire-Revised lists eight situtations and asks teacher to what degree the student exhibits behavior problems in each. The scale produces two scores: number of problem areas and the severity of behavior problems, which can then be compared to peer norms.

As an example of a behavior rating scale which may be used by both teachers as well as parents, copies of the Revised Home and School Situations Questionnaires have been reprinted on pages 25 to 30.

A detailed description of behavior rating scales for parents as well as information on where to order these assessment tools are available in Russell Barkley's **Attention Deficit Hyperactivity Disorder: A Handbook for Diagnosis and Treatment** (1990).

Behavior Rating Scales For Preschoolers

Behavior rating scales are the most commonly used instruments for evaluating students aged 4 to 17 who may have an attention deficit disorder. Unfortunately, a comparable scale for children younger than four years of age is not yet available. The Preschool Behavior Questionnaire (Behar, 1977) was designed to provide a tool for screening preschool children aged three to six using the same rationale as those questionnaires designed for school-aged students. It includes a 36-item checklist of behaviors with a three-point scaling system for raters. The validity of the preschool behavior questionnaire has not been supported by subsequent research, however (Mayes, 1987).

Peer Nominations and Ratings

Peer nominations and peer ratings may be socially valid sources of information used to determine how well students are accepted by their peers. In peer nominations, students are asked to nominate a certain number of classmates whom they like most and least. In peer ratings, classmates rate specific behaviors. Results of both of these measures indicate that students with ADD are consistently rated as less popular and more disliked than their peers. Results of recent studies indicate that peers are able to identify attention problems among their classmates (Schaughency & Rothlind, 1991).

School Records

A student's past and present cumulative records should be reviewed by the school psychologist. Such ADD symptomatology as learning problems, consistent pattern of symptoms since kindergarten, and immaturity may become evident through a study of these records. The school psychologist should be searching for evidence of the pervasive nature of ADD from historical records available.

Psychoeducational Testing

Psychometric testing of a variety of cognitive functions can be used to determine a student's intellectual ability, information processing skills, and academic achievement. These test results are helpful in understanding a student's learning style, detecting signs of learning disabilities, and discovering other conditions which might produce ADD symptoms. Subtests of several standardized tests such as the Wechsler Intelligence Sale for Children-Revised (WISC-R) and Kaufman Assessment Battery for Children (K-ABC) include tasks which are sensitive to attention and concentration. Since poor scores on these measure may occur for other reasons than the presence of ADD, results must be interpreted with caution.

Specialized Testing

In addition to traditional intelligence and achievement tests, computerized attention tests such as the Gordon Diagnostic System (Gordon, McClure, & Post, 1986) may be used to evaluate individual attention spans and impulsivity.

Medical Evaluation

Although not required under federal law, a physical and developmental neurological examination can reveal information about current and past physiological problems which may be associated with ADD symptoms. The evaluation can also serve to eliminate other explanations for behaviors supportive of Attention Deficit Disorder. The evaluation may reveal pertinent information about the student's ADD characteristics and provide information about any medical therapies that have been used.

Phase Two

Should the initial phase of the assessment process indicate a diagnosis of ADD, another phase of the assessment should follow to determine the extent that the student's Attention Deficit Disorder affects academic performance. This part of the assessment includes:

- direct observations
- academic performance measures
- trial interventions

Direct Observations

Direct observations of students interacting in their natural environments can provide objective information about a student's behavior and degree of impairment. Trained observers can create a comprehensive picture of students by studying them engaged in both structured and unstructured activities during different time periods and in diverse settings and recording observations. Direct observations reduce rater bias as they are conducted by impartial observers. The disadvantages of direct observations include the costs involved in training and data collection and the possibility that certain behaviors may be missed during limited observation time periods.

Direct observation methods vary in complexity from simply counting specific behaviors during prescribed time periods to making more detailed observations of student interactions in the

classroom environment. Several observation coding designs have been created, including the State-Event Classroom Observation System developed by Saudargass and Creed (1980), the Classroom Observation Record Form developed by Alessi and Kaye (1983) and the Restricted Academic Situation coding system developed by Raymond Barkley (1991), included on pages 31 to 34.

Observations of Preschoolers

One objective playroom observation procedure designed especially for assessment of ADD in preschool children is the Mayes Hyperactivity Observation System (Mayes, 1982). The MHOS evaluates gross motor movement, attention, and play style during a 10-minute free play period in a standardized area. Use of the MHOS and the Conners 10-item Abreviated Symptom Questionnaire (ASQ-T) is recommended as an effective combination for assessment of preschool children.

Academic Performance Measures

The quantity and accuracy of work produced by a student, as compared to peers, are good indicators of whether or not the student's learning and achievement should be of concern. Representative samples of student work as well as assigned grades are indicators of academic performance. The Academic Performance Rating Scale developed by DuPaul, Rapport, and Perriello (1991) can be used to provide data concerning a student's academic productivity in terms of quantity and accuracy of work. This scale yields four scores in addition to a total which evaluate learning ability, impulse control, academic performance, and social withdrawal. A detailed description of the Academic Performance Rating Scale, reprinted on pages 35 to 40 as well as information on where to order this assessment tool are available in Russell Barkley's **Attention Deficit Hyperactivity Disorder: A Handbook for Diagnosis and Treatment** (1990).

Trial Interventions

The use of trial interventions in the regular classroom as a part of the assessment process is recommended to help determine the severity of the disability, the potential success of various interventions, and what services are most appropriate to meet a student's individual needs.

Conflict Behavior Questionnaire

Conflict Behavior Questionnaire

The Conflict Behavior Questionnaire, created by Arthur Robin and Sharon Foster, can be used to assess patterns of negative communication in parent-adolescent relationships. Scoring instructions and norms are provided here along with details on the psychometric properties of the scale.

Description

The Conflict Behavior Questionnaire (CBQ) is a self-report inventory assessing perceived communication and conflict between parents and adolescents. Parents and adolescents complete parallel versions of the CBQ, rating their interactions over the preceding 2- 3 weeks. The parent version contains 75 true/false statements, 53 regarding the parents' appraisal of their adolescent's behavior (e.g., "My child sulks after an argument") and 22 regarding their perception of their interactions with the adolescent (e.g., "We joke around often"). The adolescent version contains 73 items, 51 regarding the adolescent's appraisal of the parent' behavior (e.g., "My mom doesn't understand me") and 22 identical to the parent form, tapping the adolescent's perception of interactions with the parent. Separate scores are obtained for each member's appraisal of (a) the other's behavior and (b) the dyadic interaction. In two-parent families adolescents complete the CBQ separately for relations with the mother and the father. Scoring is readily accomplished by constructing transparent overlays following an item key or using machine-scorable optimal-scanning answer sheets.

Purpose

The CBQ gives a broad-based estimate of how much conflict and negative communication parents and adolescents experience in their relationships. Items reflect general arguments, misunderstanding, the inability to resolve disputes, and specific verbal and nonverbal communication deficits.

Conflict Behavior Questionnaire—Parent Version

Name_____

Date_____

I am the child's ___mother ___father (check one).

I am filling this questionnaire out regarding my ___ son ___daughter (check one) who is ___ years old.

Think back over the last two weeks at home. The statements below have to do with you and your child. Read the statement, and then decide if you believe that the statement is true. If it is true, then circle **True**, and if you believe the statement is not true, circle **False**. You must circle either True or False, but never both for the same item. Please answer all items. Answer for yourself, without talking it over with anyone.

True	False	1. My child is easy to get along with.
True	False	2. My child is well behaved in our discussions.
True	False	3. My child is receptive to criticism.
True	False	4. For the most part, my child likes to talk to me.
True	False	5. We almost never seem to agree.
True	False	6. My child usually listens to what I tell him/her.
True	False	7. At least three times a week, we get angry at each other.
True	False	8. My child says I have no consideration of his/her feelings.
True	False	9. My child and I compromise during arguments.
True	False	10. My child often doesn't do what I ask.
True	False	11. The talks we have are frustrating.
True	False	12. My child often seems angry at me.
True	False	13. My child acts impatient when I talk.
True	False	14. In general, I don't think we get along very well.
True	False	15. My child almost never understands my side of an argument.
True	False	16. My child and I have big arguments about little things.
True	False	17. My child is defensive when I talk to him.
True	False	18. My child thinks my opinions don't count.
True	False	19. We argue a lot about rules.
True	False	20. My child tells me he/she thinks I am unfair.

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Conflict Behavior Questionnaire—Adolescent's Version Regarding Mother

Name _____

Date _____

Think back over the last two weeks at home. The statements below have to do with you and your mother. Read the statement, and then decide if you believe that the statement is true. If it is true, then circle **True**, and if you believe the statement is not true, circle **False**. You must circle either True or False, but never both for the same item. Please answer all items.

True False 1. My mom doesn't understand me.
True False 2. My mom and I sometimes end our arguments calmly.
True False 3. We almost never seem to agree.
True False 4. I enjoy the talks we have.
True False 5. When I state my own opinion, she gets upset.
True False 6. At least three times a week, we get angry at each other.
True False 7. My mother listens when I need someone to talk to.
True False 8. My mom is a good friend to me.
True False 9. My mom says I have no consideration for her.
True False 10. At least once a day we get angry at each other.
True False 11. My mother is bossy when we talk.
True False 12. My mom understands me.
True False 13. The talks we have are frustrating.
True False 14. My mom understands my point of view, even when she doesn't agree with me.
True False 15. My mom seems to be always complaining about me.
True False 16. In general, I don't think we get along very well.
True False 17. My mom screams a lot.
True False 18. My mom puts me down.
True False 19. If I run into problems, my mom helps me out.
True False 20. I enjoy spending time with my mother.

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Conflict Behavior Questionnaire—Adolescent's Version Regarding Father

Name _____

Date _____

Think back over the last two weeks at home. The statements below have to do with you and your father. Read the statement, and then decide if you believe that the statement is true. If it is true, then circle **True**, and if you believe the statement is not true, circle **False**. You must circle either True or False, but never both for the same item. Please answer all items.

True False 1. My dad doesn't understand me.

True False 2. My dad and I sometimes end our arguments calmly.

True False 3. We almost never seem to agree.

True False 4. I enjoy the talks we have.

True False 5. When I state my own opinion, he gets upset.

True False 6. At least three times a week, we get angry at each other.

True False 7. My father listens when I need someone to talk to.

True False 8. My dad is a good friend to me.

True False 9. He says I have no consideration for him.

True False 10. At least once a day we get angry at each other.

True False 11. My father is bossy when we talk.

True False 12. My dad understands me.

True False 13. The talks we have are frustrating.

True False 14. My dad understands my point of view, even when he doesn't agree with me.

True False 15. My dad seems to be always complaining about me.

True False 16. In general, I don't think we get along very well.

True False 17. My dad yells a lot.

True False 18. My dad puts me down.

True False 19. If I run into problems, my dad helps me out.

True False 20. I enjoy spending time with my father.

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Scoring Instructions: Conflict Behavior Questionnaire

This is a measure of communication-conflict behavior. The current 20-item version is a shortened revision, using item analysis procedures, of a longer 75-item version of the Conflict Behavior Questionnaire. A single score is obtained for each family member completing the questionnaire by following these guidelines. (Higher scores represent more negative communication.)

Parent Version

1. Add one point for each of the following items answered True: 5, 7, 8, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20. 2. Add one point for each of the following items answered False: 1, 2, 3, 4, 6, 9.

Adolescent Version

1. Add one point for each of the following items answered True: 1, 3, 5, 6, 9, 10, 11, 13, 15, 16, 17, 18. 2. Add one point for each of the following items answered False: 2, 4, 7, 8, 12, 14, 19, 20.

Means And Standard Deviations For CBQ

Score	Distressed mean (SD)	Nondistressed mean (SD)	*t*	r-pb**
Mother	12.4 (5.0)	2.4 (2.8)	15.3*	.73
Father	10.5 (5.0)	3.2 (3.0)	5.2*	.51
Teen with mother	8.4 (6.0)	2.0 (3.1)	8.2*	.50
Teen with father	7.6 (5.4)	1.6 (1.6)	4.1*	.42

* p .001

**Point biserial correlations between group membership and CBQ score.

T-Score Conversion Table For The Conflict Behavior Questionnaire-20

1. Locate the raw score for your family under the appropriate agent column (mom, dad, teen/ mom, teen/dad).

2. Read the T-score in the next column to the right.

3. T-scores over 70 are clinically elevated.

Mom	T-score	Dad	T-score	Teen/Mom	T-score	Teen/Dad	T-score
0	41	0	39	0	44	0	40
1	45	1	43	1	47	1	46
2	49	2	49	2	50	2	53
3	52	3	49	3	53	3	59
4	56	4	53	4	56	4	65
5	59	5	56	5	60	5	71
6	63	6	59	6	63	6	78
7	66	7	63	7	66	7	84
8	70	8	66	8	69	8	90
9	74	9	69	9	73	9	96
10	77	10	70	10	76	10	103
11	81	11	73	11	79	11	109
12	84	12	76	12	82	12	115
13	88	13	79	13	85	13	121
14	91	14	83	14	89	14	128
15	95	15	86	15	92	15	134
16	99	16	89	16	95	16	140
17	102	17	93	17	98	17	146
18	106	18	96	18	102	18	153
19	109	19	99	19	105	19	159
20	113	20	116	20	136	20	136

Skamp Rating Scale

Skamp Rating Scale

Name of Child_____ Age____ Grade____ Gender____

Completed by_____ Date_____

Teacher_____ Aide_____Mother_____ Father____Other_____

	Check each column which best describes this child during a classroom Period:			
	Not At All	Just A Little	Pretty Much	Very Much
1. Difficulty getting started on classroom assignments				
2. Difficulty staying on task for a classroom period				
3. Problems in interactions with peers in the classroom				
4. Problems in unteractions with staff (teacher or aide)				
5. Difficulty remaining quiet according to classroom rules				
6. Difficulty staying seated according to classroom rules				
7. Problems in completion of work on classroom assignments				
8. Problems in accuracy or neatness of written work in the classroom				
9. Difficulty attending to an activity or discussion of the class				
10. Difficulty stopping and making transition to next period				

ATTENTION		total	avg
Orienting Attention	1_10_		
Maintaining Attention	2_7_		
Directing Attention	8_9_		
Total Attention	1_2_7_		
	8_9_10_		

DEPORTMENT		total	avg
Attention to Others	3_4_		
Attention to Rules	5_6_		
Total Deportment	3_4_		
	5_6_		

	Mean	SD	M+1SD	M+2SD
Subgroup		BOYS		
Attention	.84	1.01	1.85	2.86
Deportment	.82	.82	1.64	2.46
Subgroup		GIRLS		
Attention	.41	.73	1.14	1.87
Deportment	.37	.55	.92	1.47

Revised Home and School Situations Questionnaires

Revised Home and School Situations Questionnaires

These revisions of the HSQ and SSQ were created to permit parents and teachers to rate specific problems children might have with attention or concentration. As a result, the revised scales are most useful for evaluating children in whom a concern about ADHD or ADD without Hyperactivity is the major referral issue. You can obtain four scores for the HSQ-R and two for the SSQ-R rating scale: the number of problem settings and the mean severity score. They are obtained by doing the following:

1. *Number of problem settings*. Count the number of Yes answers.

2. *Mean severity*. Sum the circled numbers and divide by the number of Yes answers.

3. *Factor I:* Compliance Situations. Sum the items listed in the scoring instructions for Factor I.

4. *Factor II:* Leisure Situations. Sum the items shown in the scoring instructions for Factor II.

Compare the child's scores to those provided in the tables of norms. Any child whose score is greater than 1.5 standard deviations above the mean for their age and sex is considered to be deviant on this scale.

Scoring Instructions: Revised Situations Questionnaires

Home Situations Questionnaire–Revised

Number of problem settings: Sum of Yes responses to all items.

Mean severity: Sum of severity ratings divided by the number of Yes responses.

Factor I: Sum severity rating (0-9) for items 3, 4, 6-11, 13, 14.

Factor II: Sum severity rating (0-9) for items 1, 2, 5-7, 11-13.

School Situations Questionnaire–Revised

Number of problem settings: Sum of Yes responses to all items.

Mean severity: Sum of severity ratings divided by the number of Yes responses.

Home Situations Questionnaire—Revised

Name of Child _____ **Date** _____

Name of Person Completing This Form _____

Does this child have problems paying attention or concentrating in any of these situations? If so, indicate how severe these attentional difficulties are.

Situations	*Yes/No* (Circle one)		*If yes, how severe?* Mild (Circle one) Severe								
While playing alone	Yes	No	1	2	3	4	5	6	7	8	9
While playing with other children	Yes	No	1	2	3	4	5	6	7	8	9
Mealtimes	Yes	No	1	2	3	4	5	6	7	8	9
Getting dressed	Yes	No	1	2	3	4	5	6	7	8	9
While watching TV	Yes	No	1	2	3	4	5	6	7	8	9
When visitors are in your home	Yes	No	1	2	3	4	5	6	7	8	9
When you are visiting someone else	Yes	No	1	2	3	4	5	6	7	8	9
At church or Sunday school	Yes	No	1	2	3	4	5	6	7	8	9
In supermarkets, stores, restaurants, or other public areas	Yes	No	1	2	3	4	5	6	7	8	9
When asked to do chores at home	Yes	No	1	2	3	4	5	6	7	8	9
During conversations with others	Yes	No	1	2	3	4	5	6	7	8	9
While in the car	Yes	No	1	2	3	4	5	6	7	8	9
When father is home	Yes	No	1	2	3	4	5	6	7	8	9
When asked to do school homework	Yes	No	1	2	3	4	5	6	7	8	9

Office Use Only: No. of problems ___ Mean severity___

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School Situations Questionnaire—Revised

Name of Child _____

Name of Person Completing This Form _____

Does this child have problems paying attention or concentrating in any of these situations? If so, indicate how severe these attentional difficulties are.

Situations	Yes/No (Circle one)		If yes, how severe? Mild (Circle one) Severe
During individual deskwork	Yes	No	1 2 3 4 5 6 7 8 9
During small-group activities	Yes	No	1 2 3 4 5 6 7 8 9
During free-play time in class	Yes	No	1 2 3 4 5 6 7 8 9
During lectures to the class	Yes	No	1 2 3 4 5 6 7 8 9
On field trips	Yes	No	1 2 3 4 5 6 7 8 9
During special assemblies	Yes	No	1 2 3 4 5 6 7 8 9
During movies, filmstrips	Yes	No	1 2 3 4 5 6 7 8 9
During class discussions	Yes	No	1 2 3 4 5 6 7 8 9

Office Use Only: No. problems____ Mean severity____

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Means And Standard Deviations For The HSQ-R By Age And Gender

Age	Number of problem settings	Mean severity	Factor I	Factor II
		Girls		
6 (n=45)				
M	4.49	3.02	11.62	6.33
SD	3.82	1.88	15.02	9.19
7 (n = 70)				
M	4.37	3.13	13.11	5.75
SD	4.13	1.75	16.74	9.86
8 (n=51)				
M	4.39	3.08	13.25	6.33
SD	3.82	1.67	16.28	10.97
9 (n = 52)				
M	4.62	3.16	13.58	8.45
SD	4.41	1.81	17.21	13.87
10 (n=45)				
M	3.56	2.99	11.87	5.74
SD	4.19	1.79	18.40	10.96
11 (n=34)				
M	2.03	3.40	6.15	3.46
SD	2.71	2.16	10.52	6.68
12 (n=21)				
M	3.19	3.15	11.43	6.00
SD	4.11	2.08	18.78	14.40
		Boys		
6 (n=54)				
M	5.44	3.39	17.46	9.10
SD	3.60	1.81	17.94	13.41
7 (n=42)				
M	3.76	3.09	13.46	7.96
SD	4.32	1.89	21.00	14.58
8 (n=37)				
M	5.19	3.61	18.43	11.36
SD	4.50	1.85	20.97	15.45
9 (n=33)				
M	4.42	3.69	15.68	7.91
SD	4.12	1.95	18.20	12.31
10 (n=41)				
M	5.15	3.17	14.95	8.78
SD	4.64	1.84	17.54	11.40
11 (n=36)				
M	4.67	3.05	13.22	8.82
SD	4.70	1.80	17.76	14.89
12 (n=20)				
M	4.00	3.86	17.29	5.41
SD	3.23	1.84	18.37	8.47

Means And Standard Deviations For The SSQ-R By Gender And Age

Note. From The Home and School Situations Questionnaires—Revised: Normative Data, Reliability, and Validity by G. J. DuPaul, 1990, unpublished manuscript, University of Massachusetts Medical Center, Worcester. Reprinted by permission of the author.

	Girls		Boys	
Age	Number of problem settings	Mean severity	Number of problem settings	Mean severity
6 (n =42)				
M	2 84	3.47	2.12	4.82
SD	3 26	2.01	3.10	2.30
7 (n = 78)				
M	2.40	3.50	3.30	3.85
SD	2 94	1 91	3 17	2 00
8 (n = 90)				
M	2.12	3.02	2.50	3.14
SD	2.59	1.36	2.80	1.41
9 (n = 78)				
M	2.79	3.81	3.49	4.23
SD	3.13	1.72	3.38	1.98
10 (n = 78)				
M	2.32	3.18	2.98	3.56
SD	2.80	1.93	3.08	1.68
11 (n = 88)				
M	2.00	2.99	3.86	4.01
SD	2.62	2.00	3.11	2.56
12 (n = 36)				
M	2 06	3 01	3 70	3 37
SD	2.64	2.03	2.94	2.01

Observation Form for Recording ADHD Behaviors During Academic Performance in the Clinic or in School

Observation Form for Recording ADHD Behaviors During Academic Performance in the Clinic or in School

Conducting The Behavioral Observations During The Restricted Academic Situation

This task is designed to observe and record symptoms of ADHD during individual academic work, such as that which might be given as homework or in-class deskwork to a child. The task involves the following procedures:

In-Clinic Observations

1. Place the child in a playroom containing toys, a small work table and chair, a one-way mirror, and an intercom. Let the child play for 5 minutes as a habituation period. 2. Enter the room and tell the child that you now have some schoolwork for him or her to do. Tell the child to sit at the small table, stay in the chair, and complete the packet of math problems. Tell the child not to play with any toys and not to leave the seat during this work time; you will be back in a while to see how much work he or she has done. Be sure to give the child a set of math problems at a difficulty level well below the child's current grade. We typically use a set that is one grade level below that grade in which the child is currently placed. 3. Leave the playroom, enter the observation room, and begin coding the child's behavior using the procedures described below. After 15 to 20 minutes, end the coding session.

In-School Observations

Observe the child in his or her regular classroom for 15 to 20 minutes when the child has been given academic work to do alone at his or her desk. You can either have the teacher give work that is from a current assignment or take in a set of math problems you have specially constructed for this exercise. In any case, be sure the child has been given enough work to occupy 15 to 20 minutes. Have the teacher tell the child to go to his or her desk, complete the assigned packet of work, and stay in the seat. Then begin to observe and record the child, using the procedures below. For a normative comparison, ask the teacher to point out an average child in that classroom and code that child's behavior during individual desk- work for the same period of time. To increase the validity of your school observations, take several observations over several days to increase the sampling of child behavior.

Coding Instructions

It is helpful to make a tape recording that contains cues for the beginning of each 30-second interval of observation. This tape can simply say, "Begin 1" and then 30 seconds later "Begin 2," and so on for the 30 observation intervals. We use 30-second intervals over a 15-minute observation period, but others have used 15- or 20-second coding intervals over 20 minutes or more of observation to increase the sensitivity of the measure. When the tape sounds the beginning of a coding interval, observe the child and place a check mark next to any of the behavior categories that occur, using the column marked for that coding interval (1, 2, 3, . . .). When the next interval begins, move to the next column and again place a check beside any of the behavior categories that occur. Once a behavior has been checked during an interval, it cannot be checked again until the next interval. At the end of the observation period, calculate the percentage occurrence of each behavior category by dividing the number of check marks for that category by the total number of recording intervals. You should also calculate the number of math problems completed and the percentage completed correctly.

Definitions

1. *Off task:* This category is checked if the child interrupts his or her attention to the tasks to engage in some other behavior. Attention is defined as visually looking at the task materials. If the child breaks eye contact with the math problems, then he or she is coded as off task.

2. *Fidgeting:* Any repetitive, purposeless motion of the legs, arms, hands, buttocks, or trunk. It must occur at least twice in succession to be considered repetitive, and it should serve no purpose. Examples include swaying back and forth, kicking one's legs back and forth, swinging arms at one's

side, shuffling feet from side to side, shifting one's buttocks about in the chair, tapping a pencil or finger repeatedly on the table, and so on.

3. *Vocalizing:* Any vocal noise or verbalization made by the child. Examples: speech, whispering, singing, humming, making odd mouth noises, clicking one's teeth, and so on.

4. *Plays with objects:* Touching any object in the room besides the table, chair, math problems, and pencil. The child may touch his or her own clothing without being considered to play with an object. However, touching toys, walls, light switches, curtains, or any other object in the room is coded in this category.

5. *Out of seat:* Any time the child's buttocks break contact with the flat surface of the seat.

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Restricted Academic Situation Coding Sheet

Interval #:	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
Off task															
Fidgeting															
Vocalizin															
Plays w/obj.															
Out of seat															
Interval #:	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30
Off task															
Fidgeting															
Vocalizing															
Plays w/obj.															
Out of seat															
Interval #:	31	32	33	34	35	36	37	38	39	40	**Total**				
Off task											/40				
Fidgeting											/40				
Vocalizing											/40				
Plays w/obj.											/40				
Out of seat											/40				

Child's Name: _____ Total: /200
Coder Initials: _____

Date: _____

Week # Initial Wk 1 Wk 2 Wk 3 Wk 4

Comments:

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Academic Performance Rating Scale

Academic Performance Rating Scale

This scale was developed to assess children's productivity and accuracy in completing school work. It also contains questions that deal with organization and attention skills. Score the scale according to the instructions below and then compare the child's scores to those in the table of norms. Scores greater than 1.5 standard deviations from the mean are considered clinically significant.

Academic Performance Rating Scale

Student _____ Date_____

Age _____Grade _____Teacher_____

For each of the below items, please estimate the above student's performance over the past week. For each item, please circle one choice only.

1. Estimate the percentage of written math work completed (regardless of accuracy) relative to classmates.	0-49% 1	50-69% 2	70-79% 3	80-89% 4	90-100% 5
2. Estimate the percentage of written language arts work completed (regardless of accuracy) relative to classmates.	0-49% 1	50-69% 2	70-79% 3	80-89% 4	90-100% 5
3. Estimate the accuracy of completed written math work (i.e., percent correct of work done).	0-64% 1	65-69% 2	70-79% 3	80-89% 4	90-100% 5
4. Estimate the accuracy of completed written language arts work (i.e., percent correct of work done).	0-64% 1	65-69% 2	70-79% 3	80-89% 4	90-100% 5
5. How consistent has the quality of this child's academic work been over the past week?	Consistently poor 1	More poor than successful 2	Variable 3	More successful than poor 4	Consistently successful 5
6. How frequently does the student accurately followteacher instructions and/or class discussion during large-group (e.g., whole class) instruction?	Never 1	Rarely 2	Sometimes 3	Often 4	Very often 5
7. How frequently does the student accurately follow teacher instructions and/or class discussion during small-group (e.g., reading group) instruction?	Never 1	Rarely 2	Sometimes 3	Often 4	Very often 5
8. How quickly does this child learn new material (i.e., pick up novel concepts) ?	Very slowly 1	Slowly 2	Average 3	Quickly 4	Very quickly 5

9. What is the quality or neatness of this child's handwriting?	Poor 1	Fair 2	Average 3	Above average 4	Excellent 5
10. What is the quality of this child's reading skills?	Poor 1	Fair 2	Average 3	Above average 4	Excellent 5
11. What is the quality of this child's speaking skills?	Poor 1	Fair 2	Average 3	Above average 4	Excellent 5
12. How often does the child complete written work in a careless, hasty fashion?	Never 1	Rarely 2	Sometimes 3	Often 4	Very often 5
13. How frequently does the child take more time to complete work than his/her classmates?	Never 1	Rarely 2	Sometimes 3	Often 4	Very often 5
14. How often is the child able to pay attention without you prompting him/her?	Never 1	Rarely 2	Sometimes 3	Often 4	Very often 5
15. How frequently does this child require your assistance to accurately complete his/her academic work?	Never 1	Rarely 2	Sometimes 3	Often 4	Very often 5
16. How often does the child begin written work prior to understanding the directions?	Never 1	Rarely 2	Sometimes 3	Often 4	Very often 5
17. How frequently does this child have difficulty recalling material from a previous day's lessons?	Never 1	Rarely 2	Sometimes 3	Often 4	Very often 5
18. How often does the child appear to be staring excessively or "spaced out"?	Never 1	Rarely 2	Sometimes 3	Often 4	Very often 5
19. How often does the child appear withdrawn or tend to lack an emotional response in a social situation ?	Never 1	Rarely 2	Sometimes 3	Often 4	Very often 5

Note. From *Teacher Ratings of Academic Performance: The Development of the Academic Performance Rating Scale* by G. J. DuPaul, M. Rapport, and L. M. Perriello, 1990, unpublished manuscript, University of Massachusetts Medical Center, Worcester. Reprinted by permission of the authors. This form may be reproduced for personal use.

Scoring Instructions: Academic Performance Rating Scale

Total score: Sum items 1-19 with the following items reverse-keyed: 12, 13, 15, 16, 17, 18, 19. Learning Ability: Sum items 3-5, 8, 10, 11, 15, 17 with items 15 & 17 reverse-keyed. Impulse Control: Sum items 6, 7, 9,12, 14, 16 with items 12 & 16 reverse-keyed. Academic Performance: Sum items 1-7, 13, 14 with item 13 reverse-keyed. Social Withdrawal: Sum items 13, 15, 17-19 with all items reverse-keyed.

Means And Standard Deviations For The Academic Performance Rating Scale By Grade And Gender

Grade	Total score	Learning Ability	Impulse Control	Academic Performance	Social Withdrawal
			Girls		
Grade 1 (*n*=40					
M	67.02	27.15	21.05	33.98	16.83
SD	16.27	8.41	4.46	8.49	4.83
Grade 2 (*n*=45					
M	72.56	29.89	22.59	36.46	18.26
SD	12.33	6.44	3.91	6.22	4.37
Grade 3 (*n*=42					
M	72.10	29.59	23.00	35.93	18.77
SD	14.43	6.85	4.92	7.34	3.82
Grade 4 (*n*=38					
M	67.79	27.29	22.15	33.32	17.41
SD	18.69	8.57	5.27	9.28	5.08
Grade 5 (*n*=44					
M	73.02	29.39	23.58	37.00	18.31
SD	14.10	6.90	4.07	6.43	4.44
Grade 6 (*n*=31					
M	74.10	30.13	23.00	36.74	19.17
SD	14.45	7.28	4.31	7.09	3.71
			Boys		
Grade 1 (*n*=42					
M	71.95	30.19	22.86	35.52	17.88
SD	16.09	7.22	5.02	8.85	4.50
Grade 2 (*n*=44					
M	67.84	28.44	20.79	33.80	16.64
SD	14.86	7.11	4.59	8.43	5.10
Grade 3 (*n*=49					
M	68.49	28.39	20.90	34.71	17.67
SD	16.96	7.31	5.47	9.08	4.73
Grade 4 (*n*=40					
M	69.77	28.50	21.78	34.36	18.40
SD	15.83	7.51	4.90	8.40	4.21

Grade	Total score	Learning Ability	Impulse Control	Academic Performance	Social Withdrawal
			Boys		
Grade 5 (n=34)					
M	63.68	26.00	19.86	32.09	16.56
SD	18.04	8.15	5.17	9.83	5.15
Grade 6 (n=38)					
M	65.24	26.64	20.08	33.22	16.78
SD	12.39	6.52	3.86	6.39	4.05

Note. From ***Teacher Ratings of Academic Performance: the Development of the Academic Performance Rating Scale*** by G. J. DuPaul, M. Rapport, and L. M. Perriello, 1990, unpublished manuscript, University of Massachusetts Medical Center, Worcester. Reprinted by permission of the authors.

The Diagnosis

Because there is no one definitive test to diagnose Attention Deficit Disorder, the "guiding principle" underlying the assessment process is the use of multiple sources of information in order to make an accurate determination (Fowler, 1991, p. 28). Information gathered from the various assessment tools described in this paper can be analyzed in order to confirm a diagnosis. No single assessment instrument can indicate an ADD diagnosis by itself. For the most accurate results, the assessment strategy should include a careful and thorough analysis of the results of several instruments.

In order to make a definitive diagnosis, the answers to the following questions need to be given careful consideration (Schaughency & Rothlind,1991; DuPaul, 1992):

- Does the student meet the DSM-III-R diagnostic criteria for an Attention Deficit Disorder?
- Does the student exhibit a significant number of behavioral symptoms of ADD according to parent and teacher reports?
- Does this student display ADD-related behaviors at a frequency that is significantly greater than that of students of the same gender and mental age?
- Do these behaviors impair the student's functioning in the school, in social relations, and/or in the home?
- At what age did the student begin exhibit ADD-related behaviors, and are these behaviors evident in a variety of situations?
- Does an alternative diagnosis or conceptualization account for the student's difficulties?

The same techniques used to diagnose this disability may also be used to evaluate treatment outcomes and determine effectiveness of educational interventions. Although there is no known cure for ADD, many treatments have proven effective "in reducing the level of symptoms or the degree to which they impair adjustment " (Barkley, 1991, p. 3). The treatment of Attention Deficit Disorders, Barkley (1991) maintains, "requires a comprehensive behavioral, psychological, educational, and sometimes medical evaluation followed by education of the individual or their caregivers as to the nature of the disorder and methods proven to assist with its management" (p. 3). Various behaviorally based treatment strategies have proved effective with students, especially if used consistently in both school and home environments. Many of these strategies help students learn to monitor their own behavior and encourage the development of positive social skills. They emphasize downplaying students' weaknesses while capitalizing on their strengths and making the "classroom environment accessible" to students with different learning characteristics (Fowler, 40).

Implications For Schools And Students

The growing numbers of students diagnosed as having an Attention Deficit Disorder during the past decade has raised concerns about students being possibly misdiagnosed and mislabeled as disabled. A school's careful assessment strategy can avoid unnecessary categorization while it provides guidance for appropriate interventions and builds upon the strengths of all students.

This strategy should include the following:

- periodic schoolwide assessments to monitor social and academic progress of all students
- ongoing modifications to the learning environment to accommodate individual learning styles of all students
- prereferral evaluation strategies to aid difficult-to-teach students and their teachers
- individual assessments of students who need additional educational services beyond prereferral strategies
- a careful, thorough assessment strategy for students identified as possibly having an Attention Deficit Disorder which:

  a) is developed and coordinated by a multidisciplinary team that includes members with specialized training in ADD

  b) combines several assessment strategies and

  c) determines eligibility as well as degree of severity

Legal Considerations Pertaining To The Evaluation Of ADD/ADHD

by Jeanne M. Kincaid, Esq.

In September 1991 three divisions of the U.S. Department of Education issued a joint policy statement regarding the treatment of students with Attention Deficit Disorder (ADD) and Attention Deficit Hyperactivity Disorder (ADHD). This statement asserted that it was not necessary to consider ADD/ADHD as a separate category under the Individuals with Disabilities Education Act (IDEA) because most such students would currently qualify under either the IDEA or Section 504 of the Rehabilitation Act of 1973.

If a school district knows or suspects that a student has ADD/ADHD, the district should determine whether it needs to evaluate the student pursuant to the IDEA or Section 504. A school district may not refuse to evaluate the possible need for special education and related services of a student with a prior medical diagnosis of ADD/ADHD solely by reason of that diagnosis. However, a medical diagnosis of ADD is not sufficient to render a child eligible for services under the IDEA. Typically, a student with ADD/ADHD is eligible for services pursuant to the IDEA under one of the following categories: specific learning disability, serious emotional disturbance or other health impairment. In order to be eligible under the IDEA, however, the student must need special education.

In instances when a student does not need special education, the school district should then consider whether the student qualifies for protection under Section 504. In order for the student to fall under Section 504 protections, the student must have a physical or mental impairment that substantially limits a major life activity. Learning is considered a substantial life activity. Some students, particularly those with ADHD, are only substantially limited with respect to their ability to control behavior. The definition of major life activities under Section 504 is not exhaustive so it is arguable that ability to get along with others might be considered a substantial life activity.

1. What Kind of Evaluation is Appropriate?

Because ADD/ADHD is often viewed as a medical condition, questions arise regarding the necessity of conducting a medical examination for identification purposes. Each state must review its state regulations for each comparable IDEA category to determine what minimal evaluations must be conducted to satisfy state eligibility criteria. Frequently, states require a medical certificate from a doctor in order to determine if a student has a serious emotional disturbance or a health impairment under the IDEA. OSEP has indicated that the IDEA does not necessarily require a school district to conduct a medical evaluation. OSEP stated that a school district is obligated to provide a medical examination for a child suspected of having ADD/ADHD if such an examination is considered necessary for diagnosing ADD/ADHD in a particular child. However, unless state law requires otherwise, a medical examination is not necessarily required to diagnose ADD/ADHD. However, if a medical examination is deemed necessary, it must be at no cost to the parent.

In a recent policy letter, OSERS stated that if a student is suspected of having ADD/ADHD that was not identified at the time of a prior evaluation, and the ADD/ADHD is potentially severe enough to satisfy the criteria applicable to a category of disability under the IDEA, then the school district must conduct an evaluation to determine whether the student is eligible for additional special

education or related services based on the ADD/ADHD.

2. Evaluation Results

Merely because a student has been diagnosed as having ADD/ADHD does not render him/her automatically eligible for special education under either the IDEA or Section 504. Once a diagnosis has been made, it is incumbent upon the district to determine if the student's condition so adversely affects educational performance as to require the provision of special education. Each IDEA category mentioned above should be considered. If the student is not found eligible under the IDEA, the district should then consider the student's protection under Section 504 (i.e., does the condition substantially limit a major life activity). It is important to note that the IDEA requires that the multidisciplinary team (MDT) include at least one teacher or other specialist with knowledge in the area of the student's suspected disability. Thus, the MDT must include someone who is knowledgeable about the possible adverse effects of ADD/ADHD on a student's educational performance.

3. Failure to Evaluate

Both Section 504 and the IDEA require a district to evaluate any student it knows or suspects has a disability and because of that disability may need special education or related services. Unlike the definition of free appropriate public education (FAPE) contained in the IDEA, FAPE under Section 504 is defined as special education or *regular education*. Thus, if a student's only needs consist of accommodations in the regular education classroom, such accommodations would be considered required as part of FAPE under Section 504.

A district cannot use as a defense to a complaint lack of knowledge that a student was in need of special education. If the district should have known of the disability and the likely need for special education, it must conduct an evaluation. A common occurrence is when a district expels a student for behavior and then later learns that the student qualifies for services either under Section 504 or the IDEA. At the time of the expulsion, if the district has reason to believe that the student has a disability and because of that disability needs special education or related services, it must conduct an evaluation.

In one unpublished OCR case, the district assessed the student for the presence of a learning disability. The tests employed were intelligence and achievement tests and a behavior evaluation scale. In finding the district out of compliance with Section 504, OCR noted that none of the evaluation measures was designed to identify or assess ADD/ADHD, even though the district had received notice that this was the student's suspected disabling condition. To resolve the case, the district agreed to reimburse the parent for the cost of the student's medical evaluation.

4. Reevaluation Requirement of Section 504

Students who have ADHD often have trouble controlling their behavior. Thus, they are likely candidates for suspensions and expulsion. Section 504 requires that any student with a disability who qualifies for protection under Section 504 must be reevaluated before any significant change in his/her placement. An expulsion is considered a significant change in placement. A suspension of more than 10 consecutive days is also considered a significant change in placement. Suspensions which cumulatively exceed more than 10 days within a school year may, too, constitute a significant change in placement.

The reevaluation requirement of Section 504 mandates that the district convene a multidisciplinary team (MDT) before making a significant change in placement. If the proposed change is due to behavior, the team must determine if the child's behavior was the result of the student's disability or the result of an inappropriate placement. Frequently school districts are cited for failing to convene MDTs when the district has repeatedly suspended a student with a disability.

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A Checklist For Determining Legal Eligibility Of ADD/ADHD Students

by Perry A Zirkel

The relationship of Attention Deficit Disorder (ADD) and Attention Deficit Hyperactivity Disorder (ADHD) with legally recognized disabilities, such as specific learning disability (SLD) and severe emotional disturbance (SED), has been a continuing controversy. [1] In the wake of a congressionally mandated Notice of Inquiry, three offices of the U.S. Department of Education issued an unusual, joint memorandum, concluding that the existing legal entitlements under the Individuals with Disabilities Education Act (IDEA) and Section 504 of the Rehabilitation Act (Sec. 504) made a separate classification unnecessary. [2]

As a result, evaluation of such students to determine whether they qualify for special education and related services under the IDEA[3] is important but not sufficient; school districts must determine whether they qualify for special education or related services under the broader coverage of Sec. 504. [4] Without such evaluation, and the related notice to the parents, school districts have been found legally lacking, for example, when they have disciplined such students for behavior that may have been caused by a legally recognized disability. [5]

The key, however, is not the diagnosis of "ADD" or "ADHD," whether by a physician or a psychologist and with or without the criteria of the DSM-III.[6] Although such opinions and sources may be considered, the controlling criteria are those of the federal and state statutes that provide procedural and substantive entitlements.[7] The following checklist provides a practical and systematic approach for determining whether an individual child with ADD or ADHD qualifies for services under the IDEA,[8] Sec. 504,[9] or related state law. Although the overlapping coverage of the relevant laws do not mandate a specific sequence, the three parts of this checklist provide an effective roadmap of the various interconnecting routes. [10]

Checklist for Determining Legal Eligibility of ADD/ADHD Students

Part I	Yes	No
1. Does the student evidence, to a preponderant extent, all the qualifications of "other health impaired" under the IDEA [11]:	☐	☐
• a chronic or acute health problem?	☐	☐
• if YES, does this problem result in limited strength, vitality, or alertness?	☐	☐
• if YES, does the limited strength, vitality, or alertness adversely affect the child's educational performance to the extent of necessitating special education?[12]	☐	☐
2. Does the student evidence, to a preponderant extent, all the qualifications for "specific learning disability" under the IDEA[13]:	☐	☐

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	Yes	No
• a basic psychological processing disorder in understanding or using language that is manifested in a severe discrepancy between achievement and intellectual ability in a) oral comprehension, b) listening comprehension, c) written comprehension, d) basic reading skill, e) reading comprehension, f) mathematics calculation, or g) mathematics reasoning?[14]	☐	☐
• if YES, is the severe discrepancy not correctable without special education and related services?[15]	☐	☐
• if YES, is the problem only secondarily or not at all attributable to a) environmental, cultural, or economic disadvantage; b) visual, hearing, or motor disabilities; c) mental retardation; or d) emotional disturbance?[16]	☐	☐
3. Does the student evidence, to a preponderant extent, all the qualifications for any other disability under the IDEA:	☐	☐
• ex. severe emotional disturbance?[17]	☐	☐
• ex. mental retardation?[18]	☐	☐
• ex. autism[19] or traumatic brain injury?[20]	☐	☐
Part II	**Yes**	**No**
4. If the student does not qualify under Part I,[21] does the child's ADD /ADHD condition meet all the qualifications under Section 504[22]:	☐	☐
• is the condition mental or physical?	☐	☐
• if YES, does it impair a major	☐	☐
• life activity, such as learning?[23]	☐	☐
• if YES, is the degree of thisimpairment substantial?	☐	☐
Part III	**Yes**	**No**
5. If the student does not qualify under Part I or Part II,[24] is the child eligible under a state law that supplements the IDEA or Sec. 504?[25]	☐	☐

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Footnotes

* The author acknowledges with appreciation the assistance of Mark G. Drenning of LRP Publications, and Liz Drake of Lehigh University, in deftly locating some of the recent cases and regulations cited herein.

1 See, e.g., Inquiry of Anonymous, 18 IDELR 129 (OCR 1991); Inquiry of Sen. Lloyd Bentsen, 16 EHLR 961 (OSERS 1990); Inquiry of Joseph Smith, EHLR 213:193 (OSEP 1989); NATIONAL INSTITUTES OFHEALTH, LEARNING DISABILITIES: A REPORT TO CONGRESS 198-200 (1987).

2 Joint Policy Memorandum, 18 IDELR 116 (OCR/OSEP/OESE 1991).

3 See, e.g., Worth County Bd. of Educ., 18 IDELR 687 (Ga. SEA 1991).

4 The most frequent but not sole Sec. 504 violation that the Office for Civil Rights (OCR) has found in ADD/ADHD cases has been the lack of proper evaluation procedures. See, e.g., Gwinnett County (GA) School District., 18 IDELR 364 (OCR 1991); Romulus (MI) Community Schools, 18 IDELR 81 (OCR 1991); Grosse Isle (MI) Township Schools, 17 EHLR 878 (OCR 1991); Prince George's County (MD) Pub. Schools, 17 EHLR 875 (OCR 1991); Farmington (MI) Pub. Schools, 17 EHLR 872 (OCR 1991); Paradise Valley (AZ) Unified School Dist., 17 EHLR 863 (OCR 1991); Buffalo Valley (ND) Special Educ. Unit, 17 EHLR 849 (OCR 1991); Baldwin County (AL) School Dist., 17 EHLR 756 (OCR 1991); Kensal (ND) Pub. Schools, 17 EHLR 391 (OCR 1991); Columbia County (GA) School Dist., 17 EHLR 586 (OCR 1991); Ohio County (KY) School Dist., 17 EHLR 528 (OCR 1990); Hyde Park (NY) Cent. School Dist., 16 EHLR 182 (OCR 1989); Cocke County (TN) School Dist., EHLR 353:169 (OCR 1988). In some cases, OCR has found that the school district, rather than stopping with IDEA eligibility, complied with the broader scope for evaluation of Sec. 504. See, e.g., Pembina (ND) Pub. School Dist., 18 IDELR 225 (OCR 1991); Ventura (CA) Unified School Dist., 17 EHLR 854 (OCR 1991); Newport News (VA) Pub. Schools, 17 EHLR 846 (OCR 1991); Weber (UT) School Dist., 17 EHLR 363 (OCR 1990). Other violations include the failure to provide parental notice of Sec. 504 safeguards, e.g., Jefferson County (CO) School Dist., 16 EHLR 520 (OCR 1989); to allow access to due process hearings, DeSoto County (MS) School Dist., 17 EHLR 843 (OCR 1991); to provide administration of medication, e.g., Pearl (MS) Pub. School Dist., 17 EHLR 1004 (OCR 1991); or to monitor that the medication is taken, e.g., San Ramon (CA) Unified School Dist., 18 IDELR 465 (OCR 1992).

5 See, e.g., Greenville (SC) School Dist., 17 EHLR 1120 (OCR 1991); Templeton (CA) Unified School Dist., 17 EHLR 859 (OCR 1991); Brittan (CA) Elementary School Dist., 16 EHLR 236 (OCR 1990); Rialto (CA) Unified School Dist., EHLR 353:201 (1989). In some cases, OCR has found no violation. See, e.g., School Administrative Unit No. 4 (NH), 16 EHLR 1282 (OCR 1990); Silver Lake (MA) Regional School Dist., 16 EHLR 1213 (OCR 1990).

6 See, e.g., Joint Policy Memorandum, supra note 2, at 117: [A school district] may not refuse to evaluate the possible need for special education and related services of a child with a prior medical diagnosis of ADD solely by reason of that diagnosis. However, a medical diagnosis of ADD is not sufficient to render a child eligible for services under [the IDEA]. See also Inquiry of Jo Thomason, 18 IDELR 536 (OSEP 1991).

7 See, e.g., Loudoun County Pub. Schools, 18 IDELR 1137 (Va. SEA 1991).

8 For the IDEA case law to date involving students with ADD or ADHD, the issue has been FAPE, not eligibility. The student was already identified as either SED, Norris v. Board of Educ., LEXIS No. 10404 (S.D. Ind. 1992); B.G. v. Cranford Bd. of Educ., 702 F. supp. 1140 (D.N.J. 1988); Hall v. Freeman, 700 F. Supp. 1106 (N.D.Ga. 1987); Martin v. School Bd., 348 S.E.2d 857 (Va. 1986); SLD, Hampton School Dist. v. Dobroski, LEXIS No. 23134 (1st Cir. 1992); Livingston v. DeSoto, 782 F. Supp. 1173 (N.D. Ga. 1992); Pettigrew v. School Bd., LEXIS No. 17838 (E.D. Va. 1989); MR, Greer v. RomeCity School Dist., 762 F. Supp. 936 (N.D. Ga. 1990); or special needs under state law, Roland M. v. Concord School Comm., LEXIS No. 14170 (D. Mass. 1989), aff'd 910 F.2d 983 (1st Cir. 1990), cert. denied, 111 S. Ct. 1122 (1991); cf. Valerie J. v. Derry Coop. School Dist., 771 F. Supp. 483 (D.N.H. 1991), order clarified, 771 F. Supp. 492 (D.N.H. 1991). The most common specific issue was tuition reimbursement, and school districts have generally prevailed, reflecting the difficulty of obtaining residential or other private placements for ADD/ADHD students. The cases that came closest to making an issue of ADD/ADHD were Roland M., where the trial court judge rejected the conclusion that the plaintiff- student was suffering from ADD but the appellate court declined to address the matter, and Valerie J., where the court ruled that conditioning an IEP on medication without parental consent was a procedural violation but then became bogged down with the matter of monetary damages.

9 In several of the cases listed supra in notes 4-5, OCR found that the student was eligible under Sec. 504. See, e.g., Pembina (ND) Pub. School Dist., 18 IDELR 225 (OCR 1991); Prince George's County (MD) Pub. Schools, 17 EHLR 875 (OCR 1991); Kensal (ND) Pub. Schools, 17 EHLR 591 (OCR 1991); Weber (UT) School Dist., 16 EHLR 363 (OCR 1990); Brittan (CA) Elementary School Dist., 16 EHLR 1226 (OCR 1990); Fullerton (CA) Joint Union H.S. Dist., EHLR 353:298 (OCR 1989); Fairfield-Suisun (CA) Unified School Dist., EHLR 353:205 (OCR 1989). However, in other cases, OCR found that evaluation revealed noneligibility. See, e.g., Anchorage (AK) School Dist., 17 EHLR 244 (OCR 1990); Jefferson Parish (LA) Pub. Schools, 16 EHLR 755 (OCR 1990).

10 The sequence represented by the three parts and the items within them are not rigid lock-steps; they may be skipped or reversed where such variations are warranted. The point is that where the

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school district suspects or has reason to suspect that the child is covered by one or more of these three parts, which are approximately analogous to concentric circles, it has a duty to evaluate the child's eligibility according to applicable procedures. See, e.g., Inquiry of Deborah Barnett, 19 IDELR 1235 (OSEP 1992); Curwensville Area (PA) School Dist., EHLR 353:292 (OCR 1989).

11 34 C.F.R. Sec. 300.7(a) and (b)(8). The multidisciplinary evaluation team may include a physician but need not include one unless required by state law. See Inquiry of Harvey Parker, 18 IDELR 963 (OSEP 1991). For an example of an ADHD child found qualified as other health impaired, see Pulaski County Special School Dist., 18 IDELR 1249 (Ark. H.O. 1992).

12 Presumably, the evidence will include the student's grades, test data, discipline records, or attendance.

13 34 C.F.R. Sec. 300.7 (a) and (b)(10). The multidisciplinary evaluation team must include certain specified members (id. Sec. 540) and procedures (id. Sec. 542-43). The team's written report, for example, must include "the educationally relevant medical findings, if any." Id. Sec. 543 (b)(5). In IDEA administrative cases to date, the issue often is placement or services, with eligibility undisputed and unclearly connected to SLD. See, e.g., In re Child with Disabilities, 18 IDELR 1061 (Conn. H.O. 1992); Livingston Bd. of Educ., 18 IDELR 1070 (N.J. H.O. 1992).

14 Id. Sec. 300.541 (a)(2). Other observable manifestations, such as hyperactivity and attention problems, and the intersecting variables of age and learning experiences, are relevant. Id. Sec.300.541 (a)(1); Inquiry of J. Sarge Kennedy, 16 EHLR 1062 (OSEP 1990). No single score shall be used to determine eligibility for this or any other discrepancy under the IDEA. 34 C.F.R. Sec. 300. 532 (d)(3). For cases where the severe discrepancy standards were not met, see, e.g., Worth County Bd. of Educ., 18 IDELR 687 (Ga. SEA 1992); cf. Kelby v. Morgan Hill Unified School Dist., 18 IDELR 831 (9th Cir. 1992) (not specifically ADD/ADHD).

15 34 C.F.R. sec. 300.7 (a) and 300.543 (b)(6).

16 Id. Sec. 300.7 (b)(10) and 300.541 (b). This criterion, which is worded in terms of "primarily," has been changed to the obverse here to be consistent with the direction of the YES-NO format.

17 Id. Sec. 300.5(a) and (b)(9); see also Perry Zirkel, A Legal Checklist for Determining "SED" Eligibility, The Special Educator, Volume 7, Issue 16, pages 257-58 (1991). For a case of an ADD student classified, over the parent's objection, as SED (under state law), see Onteora Cent. School Dist., EHLR 509:129 (N.Y. SEA 1987).

18 34 C.F.R. Sec. 300.7(a) and (b)(5).

19 Id. Sec. 300.7(a) and (b)(1).

20 Id. Sec. 300.7(a) and (b)(12).

21 Of course, a student who qualifies under Part I (IDEA) typically is also covered by Part II (Sec. 504). As suggested supra in note 10, the broader coverage of Sec. 504 allows some flexibility in sequencing.

22 Id. Sec. 104.e(j). For the sake of relative simplicity, only the criteria of the first prong of the Sec. 504 definition of handicap are listed in this item; for examples of applications of these criteria to ADD/ADHD students, see supra note 9. The alternative other two prongs are having a "record of" and being "regarded as having" such an impairment, respectively. Occasionally the second (i.e., "record of") prong comes into play in ADD/ADHD cases. See, e.g., Jefferson County (CO) School Dist., 16 EHLR 520 (OCR 1990). As a final clarification, the additional, age-based criterion for a "qualified" handicapped person is assumed here. 34 C.F.R. Sec. 104.3(k).

23 See supra note 12.

24 Similarly consonant with notes 10 and 21 supra, this sequence is not intended to suggest that the coverage of relevant state legislation and regulations is exclusive of these federal laws. Students covered by the IDEA are typically covered not only by Sec. 504 but also by state law. Moreover, in some states, the relevant law does not extend beyond the coverage of the IDEA or Sec. 504.

25 Cf. Ritchfield Joint School Dist., 18 IDELR 168 (Wis. H.O.1991) (child with "Exceptional Educational Needs" child but issue was ESY); Kelby v. Morgan Hill Unified School Dist., 18 IDELR 831, 832 (9th Cir. 1992) (no ADD/ADHD label).

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Resources

Parent Support Groups

Children with Attention Deficit Disorders (CH.A.D.D.)
499 Northwest 70th Avenue, Suite 308
Plantation, FL 33317

CH.A.D.D. is a national support group for parents of children with Attention Deficit Disorders and for educators and health care professionals with an interest in ADD. The organization has nearly 300 chapters nationwide as well as some international affiliates.

National Attention Deficit Disorder Associaton (NADDA)
19262 Jamboree Blvd.
Irvine, CA 92715
800-487-2282

The Attention Deficit Disorder Association is an association of ADD parent support groups.

Attention Deficit Information Network (Ad-In)
National Office
475 Hillside
Needham, MA 02194
(617) 455 - 9895

The Attention Deficit Information Network, Inc. is a non-profit volunteer organization offering support and information to families, individuals, and professionals through a network of 60 AD-IN chapters nationwide.

The Learning Disability Association (LDA)
4156 library Road
Pittsburg, PA 15234
(412) 341-1515

The Learning Disability Association is a national support group for parents of children with learning disabilities.

Information Centers

NICHCY (National Information Center for Children and Youth with Disabilities)
P.O. Box 1492
Washington, DC 20013
800-999-5599

Council for Exceptional Children
1920 Association Drive
Reston, VA 22091
(703) 620-3660

Tourette Syndrome Association
42-40 Dell Blvd.
Bayside, NY 11361
800-237-0717

Federal Centers

The 1990 amendments to IDEA directed the U. S. Department of Education to provide funds to support one or more centers designed to organize, synthesize, and disseminate current knowledge relating to children with attention deficit disorder. The purpose of these centers is to help educators, researchers, and parents respond to the needs of children with ADD; and to provide access to the current research knowledge base related to either (1) assessment and identification of children with ADD or (2) interventions for children with ADD. Four centers have been funded, two addressing each issue. The Centers (and the project directors) for organizing and analyzing the research knowledge base are:

Intervention:

Dr. James Swanson
University of California-Irvine
19262 Jamboree Blvd.
Irvine, CA 92715
714/856-8730

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